LOUISIANA PATIENT'S COMPENSATION FUND

STRATEGIC PLAN

FISCAL YEAR 2008-09 THROUGH FISCAL YEAR 2012-13

VISION

VISION

The vision of the Patient's Compensation Fund (PCF) is:

- to protect and maintain the integrity of the Medical Malpractice Act (R.S. 40:1299, et al)
- to help stabilize healthcare costs by providing affordable rates for medical malpractice assurance coverage
- to provide impartial and prompt compensation to affected injured parties of medical malpractice incidents

To ensure that healthcare costs are minimized for malpractice coverage, PCF will thoroughly evaluate all claims to ensure fair and timely conclusions while maintaining affordable rates. This in turn ensures that healthcare providers choose Louisiana as their location to practice, so that the citizens of the state have multiple options for their healthcare choices.

MISSION

Created by Act 817 of the 1975 Legislative Session in order to guarantee that affordable medical malpractice coverage was available to all private health care providers and to provide a stable source of compensation to injured parties of malpractice.

It is the mission of the Patient's Compensation Fund Oversight Board (Board) to direct the operation and coordinate the defense of the Patient's Compensation Fund (PCF) in a manner that will timely and efficiently meet the needs of the interested parties for whom the PCF was created to serve: the citizens of the state, parties injured as a result of medical malpractice, and Louisiana's private health care providers.

PHILOSOPHY

PCF staff will collect appropriate surcharges for each HCP participating in the fund and will process each claim fairly to ensure adequate compensation is provided to each legitimate injured party.

GOALS

1. The Board shall strive to maintain surcharge rates that are reasonable and affordable for health care providers but adequate to meet outstanding and projected liabilities.
2. The Board shall monitor annual claims payments by impartially and objectively resolving claims efficiently and timely.
3. The Board shall maintain adequate staffing levels with appropriate training and technology to provide prompt service to our customers.

LINKS TO STATEWIDE INITIATIVES

Louisiana Vision 2020 Link: **Objective 3.3 To ensure quality healthcare for every Louisiana citizen**.
Children's Budget Link: N/A
Human Resources Policies Beneficial to Women and Children: N/A
Other Links (TANF, Tobacco Settlement, Workforce Development Commission, Others) – N/A

DUPLICATION OF EFFORT

No other state agency or department performs these tasks or exercises these controls.

OBJECTIVES

1. ***The Board shall maintain the surplus described in R.S 1299.44 A (6)(a) at a level equal to at least 30% with the goal to reach 40% by July 1, 2013.***

   Beneficiary: Private health care providers, insurance companies and the injured parties will be the primary persons benefiting from this objective. With the assured financial stability for the PCF, there will be increased competition among insurance companies who are willing to write policies in Louisiana. The companies from whom insurance companies purchase their insurance will provide coverage at reduced rates, which will in turn be passed along to the health care providers when purchasing coverage. With lower costs, health care providers will be attracted to practice in Louisiana, thus affording Louisiana's citizens' options for their health care choices. Parties injured as a result of medical malpractice will be assured compensation for their injuries, as well as the care needed to ensure they are able to enjoy a satisfactory quality of life, based on their circumstances.

STRATEGY 1.1 – To expedite processing surcharge applications by automating the calculation of surcharge rates.

STRATEGY 1.2 – Continue to coordinate with actuarial consultant to refine PCF Rating Manual so classes of providers pay rates commensurate with the risk they pose.

STRATEGY 1.3 – To expedite notification to self-insured providers of their renewal dates so that payment can be received timely. To implement a notification process of impending enrollment deadlines to all other Health Care Providers.

STRATEGY 1.4 - Update and refine the experience rating program which charges the applicable surcharge for the risk associated with those enrolled health care providers who have poor PCF claims history.

STRATEGY 1.5 – To aggressively resist and defend unmeritorious or exaggerated claims while at the same time ensuring resolution of legitimate claims promptly and fairly.

STRATEGY 1.6 – To ensure reserves are established and maintained accurately and timely.

PERFORMANCE INDICATORS:

Input: Annual number of enrolled health care providers

Output: Total surcharges collected annually
Annual Claims Payments
Annual Claims Reserves

Outcome: Annual percentage increase/decrease in Surcharge rate

Efficiency: 80% of renewals processed within deadlines established in PCF's policies

Quality: Number of delinquent renewals received which results in a gap in coverage

2. To maintain an annual claims closing persistency at 100%.

Beneficiary: Injured parties will benefit from this objective by receiving compensation timely. PCF and health care providers will benefit because when claims are concluded, it saves time (interest) and money (legal fees) for all parties involved.

STRATEGY 2.1 – Maintain statistical medical review panel data and track statutorily mandated timelines by electronic diary system to facilitate timely closure.

STRATEGY 2.2 – Update PCF Medical Review Panel procedural and instructional brochure, supplied to individuals representing themselves and attorneys chosen as attorney-chairperson, so that they will know their duties as well as all statutory requirements relative to the Medical Review Panel process.

STRATEGY 2.3 – To aggressively work to shorten the time frame by 10% from the time a medical review panel opinion is reached until the time the associated claim is closed.

STRATEGY 2.4 – To continually strive to build a closer working relationship with primary carriers and self-insured's in order to know as early as possible if a claim has the potential to impact the PCF's layer of coverage. Maintain an up-to-date website to publish information to these individuals.

STRATEGY 2.5 – Proactively pursue joint settlements with primary carrier or self-insured so that PCF can negotiate while liability is still an issue.

STRATEGY 2.6 - Closely monitor and evaluate all payment requests on claims involving future medical payments to assure that expenses are reasonable, necessary and related. When indicated, utilize professional audits of medical bills. Continue to utilize the Department of Labor's Workers' Compensation "fee schedule" for these expenses.

STRATEGY 2.7 – Use defense counsel only on those claims the senior adjusters are unable to resolve.

STRATEGY 2.8 – Periodically review pending claims status reports with each individual adjuster.

STRATEGY 2.9 – Unbiased claims counsel review of requests for settlement authority to ensure consistent case evaluations.

PERFORMANCE INDICATORS:

Input: Annual number of claims opened and assigned to adjusters

Output: Annual number of claims closed

Outcome: Percentage of claims closed within five years of filing date

Efficiency: Maintaining at least 100% claims closing persistency
Annual number of claims evaluated

Quality: Annual number of claims closed without any indemnity payment

3. To promptly provide accurate information through courteous customer assistance.

Beneficiary: Claimants, health care providers, insurance carriers and their agents, will all benefit from this objective because a highly trained and well-equipped staff will be able to quickly respond to their needs.

STRATEGY 3.1 – Ensure that 100% of PCF staff has attended customer service training within 3 years of hire date and that all supervisors attend their appropriate management courses.

STRATEGY 3.2 – Ensure that sufficient staff is available to process claims, panel requests, and enrollment applications at all times. Review workload for each section and establish benchmarks, if not already in place.

STRATEGY 3.3 – Maintain appropriate technology and infrastructure for all employees so that accurate information is available for decision-making and reporting.

PERFORMANCE INDICATORS:

Input: Average caseload per Senior Adjusters
Average caseload per Adjusters (Examiner)

Output: Number of training classes attended

Outcome: 100% of staff trained in Customer Service within 9 months of hire date by June 2010

Efficiency: Information is recorded into PCF's database within established deadlines

APPENDIX A

PRINCIPAL CLIENTS AND USERS:

The Patient's Compensation Fund was established for the benefit of these groups:

private health care providers licensed and practicing in the State of Louisiana
parties injured as a result of medical malpractice committed by those health care providers, and
ultimately all citizens of Louisiana.

The health care providers receive:

- Medical malpractice coverage of $400,000, excess of $100,000, at affordable rates.
- The protection of a limitation, or statutory "cap", on damages that can be awarded for claims of medical malpractice of $500,000 plus related medical expenses.
- Entitlement to have all claims initially evaluated by a medical review panel of three health care providers before civil litigation can be initiated.
- Competitive and affordable rates brought about due to the financial stability of the Fund and the resultant attraction that malpractice insurance writers have found to issue policies in Louisiana.

Legitimate victims of medical malpractice receive:

A certain and stable source of compensation that will pay up to $400,000, excess of the providers primary source of $100,000, plus all related medical expenses, which includes the cost of custodial care whether it is provided by a business, a private individual, or even a family member.

Citizens of Louisiana receive:

Access to better, more affordable health care as a direct result of affordable malpractice insurance drawing a larger pool of health care providers, especially medical specialists, willing to practice in Louisiana.

APPENDIX B

STATUTORY AUTHORITY:

Act 817 of the 1975 Louisiana legislative session created the Patient's Compensation Fund. The Act is comprised of La. R.S. 40:1299.41 through 40:1299.49. The establishment of the Patient's Compensation Fund is specifically outlined in La. R.S. 40:1299.44.A.

The Patient's Compensation Fund Oversight Board was established by an amendment to Act 817 during the 1990 legislative session, and is found at La. R.S. 40:1299.44.D.

The limitation on damages is found at La. R.S. 40:1299.42.B.

The payment of Future Medical benefits is listed in La. R.S. 40:1299.43.

The Medical Review Panel process is outlined in La. R.S. 40:1299.47.

The PCF Rules and Regulations is found in LAC Title 37-III- Chap.1-19.

APPENDIX C

EXTERNAL FACTORS:

1. The Louisiana Judicial System:

Substantive - liberal or excessive court judgments in regard to damages by either judge or jury.

Liberal interpretations of the facts of a case as to the question of a provider's liability.

Procedural - various aspects of the malpractice statute (La R.S. 40:1299.41 et seq.) are constantly scrutinized by the state courts on the question of constitutionality. In Butler v. Flint Goodrich Hospital of Dillard University et al. the Louisiana Supreme Court held that:

> "Since the legislature's statutory solution to the medical malpractice problem furthers the states purpose of compensating victims, it is not constitutionally infirm. Overall, the Louisiana Medical Malpractice Act represents a reasonable but imperfect balance between the rights of victims and those of health care providers. It does not violate the state or federal constitutions."

The constitutionality of the statute continues to be challenged in the courts. The Medical Malpractice Act and the cap on damages is viewed “as failing to provide the plaintiffs an ‘adequate remedy’ ” as guaranteed under the provisions of La Constitution Article 1 Section 22 by those that challenge it. Even if the Supreme Court confirms prior decisions as to the constitutionality of the cap, the issue will continue to be challenged. Thus there is some degree of uncertainty as to the role and exposure of the PCF.

2. The Louisiana Department of Insurance:

At times in the past the Board's request for rate increases that the consulting actuary has determined to be necessary has been refused by the Department of Insurance. In fact, this has occurred even when the percentage rate increase sought by the Board was significantly less than actuarially indicated.

3. The Louisiana Legislature:

The Legislature could enact amendments to the statute that could make it difficult to achieve the objectives outlined above. Furthermore, the legislature could abolish the PCF and/or the Board.

4. Health Care Providers:

As to risk management, it will be up to health care providers to implement procedures that attempt to reduce the incidence of medical errors. In many instances such procedures entail **additional costs.** Some providers may decide, based upon economic considerations, not to implement such procedures.

Retention of health care providers in the state is at risk, for several reasons. In the past few years, PCF had seen an increase in health care providers participating in the Fund. When Katrina landed, health care providers scattered along with the rest of the affected population. The remaining providers carried a greater patient load. This increased patient load will cause providers to work longer hours which increases the risk of adverse incidents occurring.

As costs of medical malpractice insurance coverage increase – whether as a result of increased incidents, payouts for claims associated with Hurricane Katrina, or an increase in the medical malpractice cap – providers will leave Louisiana to practice in more favorable states.

APPENDIX D

PROGRAM EVALUATION:

The strategic planning process began with a review of the existing plan by PCF senior management comprised of the Medical Malpractice Compliance Director, the Claims Manager and the Administrative Director. An evaluation of where we are now and where we want to be was performed. Objectives were developed. An action plan comprised of various strategies to obtain our goals was laid out.

A preliminary plan was developed and presented to the Executive Director for review. Meetings were held with all supervisors to solicit input and to familiarize the supervisors of the steps they would be required to implement to achieve the goals included in PCF's final strategic plan. Once input was obtained from PCF staff, the plan was presented to the PCF Oversight Board for additional input.

PCF realizes that the two sets of customers most directly served by us – health care providers and parties injured as a result of medical malpractice - often have opposing opinions of how we should conduct our business. There is no easy solution to satisfying the needs of both sets of customers. PCF cannot **and does not** set the needs of one group above the other. Striking a balance between the two is the challenge PCF faces daily.

BENCHMARKING:

It has been difficult to find a benchmarking partner against which to measure PCF. Not all states have Patient's Compensation Funds. There is a wide diversity among the operations of the Funds that do exist. Some funds are mandatory; some include only specific types of providers; some are for specific types of injuries; some are administered by state entities; some are handled by third party administrators; some have separate caps on both economic and non-economic damages; most do not include future medical expenses although some do.

Regardless, there have been various statistical studies done by diverse groups in relation to medical malpractice settlements and judgments. PCF has determined that comparing our operations to these studies is the best avenue for benchmarking progress toward our goals.

One measure of success used by most insurance companies is their percentage of underwriting expense as compared to premiums. "Underwriting expense" represents the overhead of salaries and other costs associated with running a business. In a report distributed in November 2006, Tillinghast, a division of Towers Perrin, reported that underwriting expense over the past ten years has ranged from 16% to 22% of net premiums. In PCF's case, the administrative budget has represented from 1.5% to 2.0% of surcharge collections. PCF is very efficient in accomplishing our mission.

Another measure of success can be the number of claims closed with a payout for damages and the number of claims closed with no payout by the PCF. There are many reasons that claims are closed with no payout including:

- abandonment by the plaintiff
- failure to comply with timeframes as established in the Medical Malpractice Act
- there was no a breach in the standard of care by the health care provider found during the peer review process so the plaintiff did not pursue further action
- damages were below the $100,000 threshold for payment by the PCF
- during discovery in the post-panel process, the case was found to be without merit and concluded without payment.

According to a study compiled by the US Department of Justice, Bureau of Justice Statistics, issued in March 2007, from data submitted by seven states with comprehensive claims databases, the number of claims closed with a payout ranged from a low of 12% to a high of 38%, over the period 2000-2004. During the same period, PCF averaged payouts on 12% – 14% of our claims.

PCF is always mindful of its obligation to parties who have been injured as a result in a breach of the standard of care by a covered, qualified health care provider. Timeliness of compensation being provided to the injured party is important to the PCF. However, since PCF cannot participate in a suit until there is a judgment in excess of $100,000, or until a settlement is reached or PCF has been invited to participate, PCF cannot always close claims as timely as we would like. The PCF strives to obtain information on claims through cooperativeness with insurance companies, defendants, and plaintiffs. Not only does this benefit the injured party, but expenses are lowered through less costly interest payments. According to the US Department of Justice, Bureau of Justice Statistics report, on average claims are reported between 15 and 24 months after occurrence and resolved within a 26 to 45 months after reporting. Louisiana's statute of limitations requires claims to be reported within 12 months of occurrence but no later than 36 months from occurrence. Once reported, PCF resolves claims on average within 34 months.

Appendix E

PERFORMANCE INDICATOR DOCUMENTATION

Indicator Name/Number: Annual number of enrolled health care providers (GOAL I) / 6095

1. Indicator Type/Level: Input / K

2. Rationale: Denotes the number of healthcare providers - individuals, groups, and institutions - that voluntarily pay the surcharges that comprise the monies held in the Patient's Compensation Fund. Consequently, this number represents, at a minimum, the providers that are available to deliver healthcare to the citizens of Louisiana.

3. Data Collection Procedure: Self-Insured providers or primary insurance carriers submit all applicable documentation directly to the PCF office. Such documents consist of applications, certificates of insurance, surcharge payments, self-insured security deposits, etc. Information regarding enrollment is entered into PCF's database and certificates of enrollment are issued to the healthcare provider.

4. Frequency and Timing of:
   - Collection - documentation is submitted and collected daily
   - Reporting - annually for actuarial review

5. Calculation Methodology: Any provider who pays an individual surcharge is counted as a single provider. Hospitals, clinics, nursing homes, surgical centers, dialysis centers, etc., are counted as single providers. Health care providers that are employees of such facilities, but are not required to pay individual surcharges, are not counted separately, but are included in the single provider count of the facility. Physicians, Certified Registered Nurse Anesthetists, Physician's Assistants, Surgical Assistants, Clinical Nurse Specialists, Nursing Practioners, Nurse Mid-Wives, Dentists, and Oral Surgeons are required to pay individual surcharges, so each provider is counted individually. RN's, LPN's, lab techs, radiology techs, etc. are not required to pay individual surcharges if they are employees of enrolled health care providers, so they are not counted.

6. Aggregations or Disaggregating: Total providers are also sub-categorized into:
   - Provider type (physician, hospital, dentist, nursing home, CRNA, All Other, etc.)
   - Physician class (physicians are rated according to 11 classes)
   - Physician specialty (physicians are further categorized as to specialty)

7. PCF Surcharge Section is responsible for data collection, accuracy and integrity. Administrative Director and Executive Director are responsible for gathering and reporting data.

8. Limitations or Weaknesses: Since participation in the Patient's Compensation Fund is voluntary, not all healthcare providers will be counted. However, PCF does feel that the majority of providers who are eligible DO participate.

9. Management Usage: This information is used by the actuary to determine exposure, which is used in the calculation of surcharge rates. It is also used in the calculation of the statutorily required surplus. Finally, management will use this information to determine staffing levels.

Indicator Name: Total surcharges collected annually (GOAL I) / 6092

1. Indicator Type / Level: Output / K

2. Rationale:This indicator shows how much is paid into the PCF by enrolled health care providers annually.

3. Data Collection Procedure: All payments are sent directly to the PCF Surcharge Section and are posted to PCF's database.

4. Frequency and Timing:
   - Collection - payments are received and are posted daily
   - Reporting – monthly to the PCF Oversight Board, annually to the actuary and as needed for management purposes

5. Calculation Methodology: How much a provider must pay is based upon current rates published annually in the PCF Rate Manual. Through upgrades to PCF's in-house computer system, automation of the rate calculation will ensure that the provider is paying the correct surcharge before posting the payment to the database.

6. Aggregations or Disaggregating: Total surcharge payments are sub-categorized by type of provider, physician class, and physician specialty.

7. PCF Surcharge Section is responsible for data collection, accuracy and integrity. Administrative Director and Executive Director are responsible for gathering and reporting data.

8. Limitations or Weaknesses: none

9. Management Usage: This information is used by the actuary in the calculation of surcharge rates. It is also used in the calculation of the statutorily required surplus.

Indicator Name: Annual claims payments (GOAL I) / 10401

1. Indicator Type / Level: Output / K

2. Rationale: Represents actual claims expenditures. This indicator shows actual loss experience. It also represents the other important factor analyzed by actuaries to determine recommended rates. Claims payments tracked for 5 or 10 years can help actuaries to develop trends, which aid in determining reasonable and sufficient rates to meet the needs of future claims.

3. Data Collection Procedure: All claims payments are processed by the PCF Claims Section through PCF's database.

4. Frequency and Timing of:
    - Collection – daily
    - Reporting – monthly to the PCF Oversight Board, annually to the actuary and as needed for management purposes

5. Calculation Methodology: The amounts that are paid for indemnity (settlements or judgments) are based upon:
    - The nature and extent of the injury
    - The age of the claimant
    - An evaluation of the likelihood of a finding of liability
    - The jurisdiction
    - The capabilities of the plaintiff attorney
    - Cooperation from the primary insurer, which is a MAJOR yet UNCONTROLLABLE factor
    - Judicial interest exposure
    - Medical expenses already incurred and expected to be incurred in the future.

    Expense payments are based upon actual incurred expenses. Future Medical payments, if determined necessary by a court or by agreement between the parties, are paid as incurred.

6. Aggregations/Disaggregating: Payments are categorized as:
    - Indemnity

- Interest
- Future Medicals
- Legal and Other Expenses

7. PCF Claims Section is responsible for data collection, accuracy and integrity. Administrative Director and Executive Director are responsible for gathering and reporting data.

8. Limitations or Weaknesses: Many of the factors related to settlements of cases are outside the control of the PCF. If the healthcare provider, or his/her insurer, chooses not to timely settle a case, PCF is also on hold. This is a result of case law. When a judgment is reached in a case, PCF is responsible for paying judicial interest, regardless of whether we tried to actively pursue settlement of the claim or not and regardless of whether the healthcare provider paid policy limits or less. Once a healthcare provider settles a claim for policy limits ($100,000), PCF can no longer argue liability, only causation and damages. This limits the PCF's defense actions. In addition PCF must always be cognizant of future medical expenses and legal costs. At times, PCF has been unable to conclude settlement offers in order that other obligations are met.

9. Management Usage: This information is used by the actuary in the calculation of surcharge rates. It is also used in the calculation of the statutorily required surplus. Management uses this information for fiduciary responsibility and settlement strategy.

Indicator Name/Number: Annual claims reserves (GOAL I) / 10399

1. Indicator Type / Level: Output / K

2. Rationale: Represents the estimated liability exposure for a claim. A reserve is set by the Claims Section based upon professional judgment of its value. The reserves are a very important aspect of what the actuaries consider when they analyze data and recommend proposed rate increases/decreases.

3. Data Collection Procedure: The Claims Section establishes the reserves on claims based on available information, payments or judgments on similar cases and records that information into PCF's database.

4. Frequency and Time of:
   - Collection – daily
   - Reporting – monthly to the PCF Oversight Board, annually to the actuary and as needed for management purposes

5. Calculation Methodology: There are a number of factors that the Claims Department takes into consideration when determining the appropriate reserves for a particular claim such as:

    - The nature and extent of the injury
    - The age of the claimant
    - An evaluation of the likelihood of a finding of liability
    - The jurisdiction
    - The capabilities of the plaintiff attorney
    - Cooperation from the primary insurer, which is a MAJOR yet UNCONTROLLABLE factor
    - Judicial interest exposure
    - Medical expenses incurred and expected to be incurred.

6. Aggregations/Disaggregating: Total reserves are also categorized as follows:

    - Indemnity reserves (settlement or judgments)
    - Future Medical reserves (if applicable)
    - Legal and Other Expense reserves

    Additionally, reserves are sub-categorized by provider type and physician class and specialty.

7. PCF Claims Section is responsible for data collection, accuracy and integrity. Administrative Director and Executive Director are responsible for gathering and reporting data.

8. Limitations: A reserve is an estimation of the value of a claim based largely on past court cases and settlements. Therefore, it is not an exact science. At settlement or judgment a determination is made as to whether the claimant will continue to incur medical expenses related to the malpractice.

9. Management Usage: This information is used by the actuary in the calculation of surcharge rates. It is also used in the calculation of the statutorily required surplus. Management uses this information for fiduciary responsibility and settlement strategy.

Indicator Name: Annual percentage increase/decrease in Surcharge Rate (GOAL I) / NEW

1. Indicator Type / Level: Outcome / S

2. Rationale: This represents what the Board, based upon recommendations from their consulting actuary, believes is needed to have rates that are both sufficient in regard to outstanding liabilities and reasonably affordable for health care providers.

3. Data Collection Procedure:The Board must annually provide the consulting actuary with surcharge collection (revenue/exposure) data and claims payment data. The actuary performs an analysis of the data and reports to the Board with recommended rate increases/decreases. The Board reviews this analysis and votes on proposed rate changes. The Louisiana Department of Insurance must then approve or deny the Board's proposed rate changes.

4. Frequency and Time of:

    - Collection – annually
    - Reporting – annually

5. Calculation Methodology: Actuarial Science

6. Aggregations or Disaggregating: Analysis is performed as to total providers and payments made on behalf of those providers, but are also subcategorized by provider type and physician class.

7. Each PCF Section is responsible for data collection, accuracy and integrity. The PCF IT Section is responsible for gathering and reporting data. Administrative Director and Executive Director are responsible for review of the data. The actuary is responsible for professional analysis of the data. The PCF Oversight Board is responsible for deciding actual rate change.

8. Limitations: A request for a change in rate may be different than what is actuarially indicated in order to keep rates reasonable and to receive approval from Department of Insurance. The rate may also be affected by the statutorily-mandated surplus.

9. Management Usage: Management will use this information as a prediction of adequate reserves and future losses.

Indicator Name: 80% of renewals processed within deadlines established in PCF's policies (GOAL I) / NEW

1. Indicator Type / Level: Efficiency / S

2. Rationale: Represents the productivity of the Surcharge Section in notifying providers of impending renewal deadlines. Three notices are sent to all self-insured providers. PCF will begin to send notification to providers with primary insurance of their impending enrollment renewal deadline. Since this is a new process, the percentage of renewals sent is set at a rate that PCF feels will be achievable and still be accurate and timely.

3. Data Collection Procedure: All renewals are processed by the PCF Surcharge Section and are posted to PCF's database.

4. Frequency and Time of:
   - Collection – daily
   - Reporting – quarterly or as needed

5. Calculation Methodology: Renewals for self-insured providers are mailed 90, 45 and 15 days prior to the current enrollment ending date. The renewals should be processed timely so that the provider has a certificate of enrollment issued in the provider's name to show continuous coverage. Renewal notices for providers with primary coverage will begin to be mailed approximately 60 days prior to the ending date of the current enrollment. If received the renewal and all pertinent documentation are received timely, the provider should be issued a certificate of enrollment to show continuous coverage. The date the check is received by PCF will be the date used to begin calculating whether the enrollment was processed within the deadline established in PCF's policies.

6. Aggregations/Disaggregating: Renewals are classified into those for health care providers with underlying coverage and self-insured providers.

7. PCF Surcharge Section is responsible for data collection, accuracy and integrity. Administrative Director and Executive Director are responsible for gathering and reporting data.

8. Limitations: Since participation in the Patient's Compensation Fund is voluntary, providers are not required to renew.

9. Management Usage: This information is used by management to determine productivity of Surcharge staff, retention of providers, and staffing levels.

Indicator Name: Number of delinquent renewals received which results in a gap in coverage (GOAL I) / NEW

1. Indicator Type / Level: Quality / S

2. Rationale: Represents those health care providers lacking coverage for a period of time. Exposes the provider to damages above the cap because there was no participation in the PCF for the lapsed time.

3. Data Collection Procedure: Reports will be run against the PCF database for any provider who did not timely renew.

4. Frequency and Time of:
   - Collection – quarterly
   - Reporting – quarterly and as needed

5. Calculation Methodology: Count of non-renewals and gapped coverage enrollments.

6. Aggregations/Disaggregating: none

7. PCF Surcharge Section is responsible for data collection, accuracy and integrity. Administrative Director and Executive Director are responsible for gathering and reporting data.

8. Limitations: none

9. Management Usage: This information is used by management to determine quality of service provided to health care providers by the Patient's Compensation Fund and the stability of coverage issues that healthcare providers see in Louisiana's environment.

Indicator Name: Annual number of claims opened and assigned to adjusters (GOAL II) / NEW

1. Indicator Type / Level: Input / S

2. Rationale: Represents the number of complaints, against qualified providers and for which fees have been paid, filed with the PCF. These complaints allege one or more providers committed medical malpractice in the treatment of a particular patient. The annual incidence of alleged malpractice for providers enrolled in the PCF.

3. Data Collection Procedure: Complaints are filed first with the Commissioner of Administration then transmitted to the PCF and all relevant data (claimant name, defendant provider name(s), date of alleged malpractice, date of filing) is entered into PCF's database.

4. Frequency and Time of:
   - Collection – daily
   - Reporting – monthly to the PCF Oversight Board, annually to the actuary and as needed for management purposes

5. Calculation Methodology: Regardless of the number of defendants, the claim of a patient is listed as a single complaint.

6. Aggregations/Disaggregating: Complaints are sub-categorized by provider type, physician class and physician specialty.

7. PCF Panel Section and Claims Section are responsible for data collection, accuracy and integrity. Administrative Director and Executive Director are responsible for gathering and reporting data.

8. Limitations: There may be a lag time between when a complaint is filed and when it is assigned to an adjuster if the appropriate filing requirements are not met upon receipt of the complaint. Plaintiffs have 45 days from acknowledgment date of receipt of a complaint in which to meet the filing requirements.

9. Management Usage: This information is used by the actuary to determine exposure, which is used in the calculation of surcharge rates. It is also used in the calculation of the statutorily required surplus. Frequency trends may be derived from this information so that PCF can assist providers with loss prevention measures. Finally, management will use this information to determine staffing levels.

Indicator Name: Annual number of claims closed (GOAL II) / NEW

1. Indicator Type / Level: Output / S

2. Rationale: Represents a measure of liability and workload for Claims. Many claims are closed during the Medical Review Panel process, either because it was abandoned by the plaintiff or because the Panel found the case to be without merit and the plaintiff decided not to pursue the case further. When a claim exists past the Panel stage, a potential liability exists to the PCF. The fewer cases handled by an adjuster, the greater attention the adjuster can spend to ensure that injured parties are compensated fairly and quickly. When a claim is closed, the reserves on that claim are eliminated thus reducing total case reserves and reducing impact to surcharge rates.

3. Data Collection Procedure: Notice of panel dismissals must be sent directly to PCF and Panel Section updates PCF's database. Claims adjusters request updates on cases and as information is obtained, PCF's database is updated.

4. Frequency and Time of:
   - Collection – daily
   - Reporting – monthly to the PCF Oversight Board and as needed for management purposes

5. Calculation Methodology: A claim cannot be closed before the Panel is closed. Only closed claims are counted.

6. Aggregations/Disaggregating: none (Or should we put something here that we segregate into "regular" and future med, then disclose that we pay on FM 'til death – in many, but not all, FM cases? Do we segregate into those paid by judgment vs settlement vs no payment?)

7. PCF Panel Section and Claims Section are responsible for data collection, accuracy and integrity. Administrative Director and Executive Director are responsible for gathering and reporting data.

8. Limitations: PCF must actively pursue panels and claims being closed as plaintiffs and their attorneys are not diligent regarding notification of closure/dismissal. Also, since PCF is not a party to the suit until there is a judgment in excess of $100,000 or after a settlement is reached or invited to participate, information is not readily available on the status of a case.

9. Management Usage: Management uses this information to predict liability and workload.

Note: It should be noted that cooperation from primary insurers continues to be a major obstacle in attaining this goal and is, obviously, outside the control of this agency.

Indicator Name: Percentage of claims closed within five years of filing date (GOAL II) / NEW

1. Indicator Type / Level: Outcome / S

2. Rationale: Represents percentage of filed cases that proceed through the Medical Review Panel and Claims process. It also indicates how good a job the adjuster, the attorney chairperson and the PCF are doing in monitoring the cases and making sure they move at a reasonable pace to conclusion.

3. Data Collection Procedure: Opinions are required to be sent to the PCF within 5 days of the signing of the decision by the panelists and the data is recorded in the PCF database. As adjusters obtain information regarding status of claims once they have completed the panel process, the data is recorded in the PCF database.

4. Frequency and Timing of:
   - Collection - daily
   - Reporting – monthly to the PCF Oversight Board and as needed for management purposes

5. Calculation Methodology: The status of each claim is monitored, as well as the filing date, whether the opinion has been received and the date of the opinion. When a claim is closed, the closing date is updated.

6. Aggregations/Disaggregating: A claim is opened once qualification/participation in the PCF has been determined and when the appropriate filing requirements have been met. Until the panel is completed, the Claims Section does little more than monitor cases, as many panels are closed with no further action. After a panel is concluded, regardless of the Panel outcome, a plaintiff may file a suit within 90 days. No further action may be taken after that time on concluded panels.

7. PCF Panel Section and Claims Section are responsible for data collection, accuracy and integrity. Administrative Director and Executive Director are responsible for gathering and reporting data.

8. Limitations: The life-cycle of a claim, from date of incident until conclusion, is greater than 5 years. Panels can be requested up to one year after the incident. Panels can last at least two years or longer if a court-ordered extension is granted. If a claim goes to trial, the life-cycle is lengthened. Obtaining information from plaintiffs and their attorneys, attorney chairpersons, insurers and others involved in a claim can be difficult. Cases may have concluded, but PCF will not know, regardless of the requests sent to the involved parties.

9. Management Usage: Management uses this information to predict expenses and reserves and the resulting affect on surcharge rates, for trend analysis of claims frequency, and to determine productivity of the adjusters and adjuster workload.

Indicator Name: Maintaining at least 100% claims closing persistency (GOAL II) / New

1. Indicator Type / Level: Efficiency / K

2. Rationale: An effective claims department should be closing as many files as it opens so that a backlog does not develop. Each claim should be reviewed on a periodic basis to ensure that attorneys do not allow cases to remain unnecessarily inactive for unreasonable periods of time. Parties injured as a result of malpractice are thereby ensured that compensation is received timely.

3. Data Collection Procedure: Once qualification/participation has been determined and the appropriate filing requirements have been met, the claim is assigned to an adjuster for review. When PCF receives information regarding the status of the claim, PCF's database is updated.

4. Frequency and Timing of:
   - Collection – daily
   - Reporting – monthly to the PCF Oversight Board and as needed for management purposes

5. Calculation Methodology: A panel is not closed until all statutorily required documentation is in the file. It is then closed and PCF's database is updated. Claims cannot be closed until the associated panel is closed.

6. Aggregations/Disaggregating: none

7. PCF Panel Section and Claims Section are responsible for data collection, accuracy and integrity. Administrative Director and Executive Director are responsible for gathering and reporting data.

8. Limitations: Collecting the information to determine the status of the claim involves parties who may not be willing to share the information, such as plaintiff attorneys, plaintiffs and the health care provider. Through case law, it has been established that PCF is not a party to the case until there is a judgment in excess of $100,000 or one or more of the defendants has settled or until one group invites PCF to a joint settlement negotiation.

9. Management Usage: As information becomes available and PCF's database is updated, this information may used by the actuary to determine exposure, which is used in the calculation of surcharge rates. Frequency trends may be derived from this information so that PCF can assist providers with loss prevention measures. Finally, management will use this information to determine staffing levels.

Indicator Name: Annual number of claims evaluated (GOAL II) / 10400

1. Indicator Type / Level: Efficiency / S

2. Rationale: Provides a measure of productivity and workload for Claims. As the adjusters obtain facts about a claim, it is reviewed and evaluated so that it may be brought to closure. Settlement authority must be granted by supervisors, the Claims Manager, the Executive Director and the Board. This information shows the progress of claims through the settlement process. The quicker cases are evaluated by an adjuster, the faster injured parties are compensated.

3. Data Collection Procedure: When a case is assigned to a senior adjuster, an evaluation is performed. As additional information is obtained, additional evaluations are done. When settlement authority is requested, the claims counsel meets to discuss the case. These events will be documented and recorded in PCF's database.

4. Frequency and Time of:
   - Collection – daily
   - Reporting – monthly for management purposes

5. Calculation Methodology: Each case that is assigned to a senior adjuster and each claims counsel meeting will be counted.

6. Aggregations/Disaggregating: none

7. PCF Claims Section is responsible for data collection, accuracy and integrity. Administrative Director and Executive Director are responsible for gathering and reporting data.

8. Limitations: PCF must actively pursue obtaining information on claims as plaintiffs and their attorneys are not diligent about keeping PCF informed. Also, since PCF is not a party to the suit until after there is a judgment in excess of $100,000 or a settlement is reached or invited to participate, information is not readily available on the status of a case.

9. Management Usage: Management uses this information to monitor productivity and workload.

Indicator Name: Annual number of claims closed without any indemnity payment (Goal II) / NEW

1. Indicator Type / Level: Quality / S

2. Rationale: A claim is opened once the appropriate filing requirements have been met. Many claims are closed during the Medical Review Panel process, either because it was abandoned by the plaintiff or because the Panel found the case to be without merit and the plaintiff decided not to pursue the case further. Additional claims are closed because the value of the claim is less than $100,000. Since PCF provides excess coverage, the fewer claims that reach this excess layer the better. By closing unmeritorious claims promptly, adjusters are able to process legitimate claims faster so that the injured party receives compensation quickly. Claim that are closed without an indemnity payment may reduce overall aggregate case

reserves. Liability to the fund is accurately tracked so that health care providers are not charged unnecessarily for invalid claims.

3. Date Collection Procedure: Once the appropriate filing requirements have been met, the claim is assigned to an adjuster for review. When PCF receives information regarding the status of the claim, PCF's database is updated.

4. Frequency and Timing of:
   - Collection - daily,
   - Reporting - monthly or as needed

5. Calculation Methodology: In the absence of any settlement, judgment, or future medical payment, a claim is considered closed without payment and PCF's database is updated. Legal and miscellaneous expenses are not considered in these situations. Claims cannot be closed until the associated panel is also closed.

6. Aggregations/Disaggregating: none

7. Both PCF Panel Section and Claims Section are responsible for data collection, accuracy and integrity. Administrative Director and Executive Director are responsible for gathering and reporting data.

8. Limitations: PCF must actively pursue obtaining information on claims as plaintiffs, their attorneys and health care providers are not diligent about keeping PCF informed. Also, since PCF is not a party to the suit until there is a judgment in excess of $100,000 after a settlement is reached or invited to participate, information is not readily available on the status of a case.

9. Management Usage: Management uses this information to predict expenses and reserves and the resulting affect on surcharge rates, for trend analysis of claims frequency, and to determine productivity of the adjusters and adjuster workload.

Indicator Name: Average caseload per Senior Adjuster (GOAL III) / 10406

1. Indicator Type / Level : Input / S

2. Rationale: Represents the number of active claim files for which an individual adjuster is responsible. The more files an adjuster is handling, the less time that can be devoted to each file. This gives an indication of how well the claims department is performing their duties of properly investigating, evaluating and resolving claims. Senior adjusters should

perform many of the duties that are often delegated to attorneys, such as settlement, negotiation, and evaluation of liability. The quality of the adjusting process (investigation, evaluation and resolution) can sometimes be in direct proportion, either positively or adversely, to an adjuster's caseload.

3. Data Collection Procedure: The Claims Supervisors assign cases to adjusters. When information becomes available that a claim may have an impact on the fund, the claim is assigned to a senior adjuster.

4. Frequency and Time of:

   - Collection – daily
   - Reporting – monthly or as needed

5. Calculation Methodology: Reports are run monthly, totaling the number of claims that are assigned to each Senior Adjuster and an average is calculated. Through comparison with Office of Risk Management and national averages for other Claims Sections, no more than 150 cases should be assigned to a Senior Adjuster for optimal performance.

6. Aggregations/Disaggregating: none

7. PCF Claims Section is responsible for data collection, accuracy and integrity. Administrative Director and Executive Director are responsible for gathering and reporting data.

8. Limitations: As PCF is not a party to a claim until there is a judgment in excess of $100,000, one or more defendants have reached a settlement or until invited, claims may not be resolved timely.

9. Management Usage: Management uses this information to monitor productivity and workload.

Indicator Name: Average caseload per Adjusters (Examiners) (GOAL III) / 10405

1. Indicator Type / Level: Input / S

2. Rationale: Represents the number of active claim files for which an individual adjuster is responsible. The more files an adjuster is handling, the less time that can be devoted to each file. This gives an indication of how well the claims department is performing their duties of properly investigating, evaluating and resolving claims.

3. Data Collection Procedure: Once a filing fee is paid, a claim is opened. The Claims Supervisors initially assign all claims to adjusters. As information is gathered that the claim may have a potential impact on the fund, the claim is re-assigned to a Senior Adjuster.

4. Frequency and Timing of:
   - Collection – daily
   - Reporting – monthly or as needed

5. Calculation Methodology: Reports are run monthly, totaling the number of claims that are assigned to each Adjuster and an average is calculated. These Adjusters are also responsible for the future medical claims. When assigning a claim, the Claims Supervisor strives to achieve a balanced workload among the employees.

6. Aggregations/Disaggregating: none

7. PCF Claims Section is responsible for data collection, accuracy and integrity. Administrative Director and Executive Director are responsible for gathering and reporting data.

8. Limitations: Claims are setup when the filing fee has been paid. PCF must actively pursue obtaining information on claims as plaintiffs, their attorneys and health care providers are not diligent about keeping PCF informed. Also, since PCF is not a party to the suit until after there is a judgment in excess of $100,000, a settlement is reached or invited to participate, information is not readily available on the status of a case. On average, a claim has an average life of five years. However, some of PCF's claims are more than 15 years old.

9. Management Usage: Management uses this information to monitor productivity and workload.

Indicator Name: Number of training classes attended (GOAL III) / NEW

1. Indicator Type / Level: Output / K

2. Rationale: The need for a trained work force has been recognized by the Department of Civil Service. Training classes are available for supervisory level employees. This training focuses on the management skills needed to provide a dedicated, motivated staff to address the needs of PCF's customers. To maintain a high level of customer service and ensure compliance with applicable state rules and regulations, PCF will monitor and track supervisor training.

3. Data Collection Procedure: PCF will establish training goals for supervisors, based on Department of Civil Service guidelines. Additional training classes related to continuing education, may be added as well.

4. Frequency and Timing of:
   - Collection – daily
   - Reporting – quarterly or as needed

5. Calculation Methodology: PCF will record the training classes supervisors attend, through either CPTP or other continuing education.

6. Aggregations/Disaggregating: none

7. PCF Human Resources Section is responsible for data collection, accuracy and integrity. Administrative Director and Executive Director are responsible for gathering and reporting data.

8. Limitations: none

9. Management Usage: Management uses this information to monitor compliance.

Indicator Name: 100% of staff trained in Customer Service within 9 months of hire date by June 2010 (GOAL III) / NEW

1. Indicator Type / Level: Outcome / K

2. Rationale: Customer Service is very important to PCF. Having employees who treat our customers with respect and integrity reflects positively on the agency and creates a feeling of confidence and trust.

3. Data Collection Procedure: All employees will be required to attend a customer service training class within 9 months of their hire date.

4. Frequency and Timing of:
   - Collection – daily
   - Reporting – quarterly or as needed

5. Calculation Methodology: PCF will record the training classes that employees attend.

6. Aggregations/Disaggregating: none

7. PCF Human Resources Section is responsible for data collection, accuracy and integrity. Administrative Director and Executive Director are responsible for gathering and reporting data.

8. Limitations: CPTP may not hold classes as often as necessary to ensure that the employee is able to take the class within 9 months of hire date, or the classes may fill quickly.

9. Management Usage: Management uses this information to monitor compliance. Random customer service surveys may be given to PCF's customers for feedback.

Indicator Name: Information is recorded into PCF's database within established deadlines (GOAL III) / NEW

1. Indicator Type / Level: Efficiency / S

2. Rationale: Accurate information is required in order to make decisions regarding coverage, qualification, compliance with statutory deadlines, evaluation of claims, and establishing reserves. Many of PCF's claims result in litigation related to one or more of these issues. Therefore it is very important that information be entered timely into PCF's database.

3. Data Collection Procedure: The functions of work in each section at PCF will be evaluated and ranked in priority. Benchmarks will be established for those functions designated as highest priority, which will include items listed in the Medical Malpractice Act, R.S 40:1299, et al. As work is processed, it will be compared against the benchmark for quantity, timeliness and accuracy.

4. Frequency and Timing of:
   - Collection – daily
   - Reporting – quarterly or as needed

5. Calculation Methodology: Reports will be run quarterly, comparing benchmarks against actual performance, on an employee basis and for each section.

6. Aggregations/Disaggregating: none

7. Each PCF Section is responsible for data collection, accuracy and integrity. Administrative Director and Executive Director are responsible for gathering and reporting data.

8. Limitations: none.

9. Management Usage: Management uses this information to monitor productivity and workload.